This form may be completed online, printed and mailed to the address listed below.

EMPLOYMENT VERIFICATION FORM

09/02

Department of Health & Human Services
Regulation and Licensure
Credentialing Division
P. O. Box 94986
Lincoln, NE 68509-4986
Fax (402) 471-1066
Telephone (402) 471-0537

NURSE AIDE: COMPLETE THIS SECTION:

Social Security Number _____

Name _____
Last First Middle Initial

Other Previously Used Last Names(s)_____

Address _____
Street Apt. # City / State Zip Code

Home Phone #_____ Work or Cell Phone #_____

Signature _____ Date_____
(optional)

EMPLOYER: COMPLETE THIS FORM

Employer's name and mailing address:

_____

_____

_____

Employer's Telephone Number _____

Brief Description of duties performed while employed:

(All Employers Must Complete the following section in the presence of a notary public.)

I certify that the nurse aide named above (is/was) employed by me to perform nursing or nursing-related services for monetary compensation from _____ to _____.
(month, day, year) (month, day, year)

Signature _____ Date Signed _____

Title _____

Sworn and subscribed before me on this _____ day of _____, 20__, In the County of _____,

In the State of _____.

_____
Signature of Notary Public

(SEAL)

_____
Date Commission Expires